THIRD PARTY ELECTION FORM

Please be sure to include claim number on form.

Claimant's name	Claim Number

☐ Check here if address has changed, and enter new address below

Claimant's mailing address

City State ZIP

Name of third party responsible for accident (exclude employer or co-employee)	Date of accident	Time of accident ☐ AM ☐
Responsible party's address City State ZIP		
Description and location of accident		
Witness to accident Address City State ZIP Phone number		

PLEASE SELECT AND COMPLETE OPTION A OR OPTION B

OPTION A. MY ATTORNEY OR I WILL PURSUE THIRD PARTY ACTION

I wish to seek recovery from the third party myself. I understand that if any recovery is made I must repay the Self Insured employer for my industrial insurance benefits. I also understand that I must notify the Self Insurer if and when I file a lawsuit. Finally, I authorize the Self Insurer to communicate with my attorney.

SIGNATURE **X** Date:

Attorney's name	Attorney's address
Attorney's phone number	City State ZIP

OPTION B. I ASSIGN THE ACTION TO THE SELF INSURED EMPLOYER

I wish to assign any cause of action that I may have against a third party to the Self Insured employer. I do not intend to pursue a third party action on my own and no recovery has yet been made. I authorize the release of information from my claim file so that a third party action may be pursued. I understand that this assignment does not pertain to loss of consortium (love, affection and companionship) claims of spouses, children or beneficiaries.

SIGNATURE **X** Date:

Please complete entire form and mail to: